U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210

File Number:

CA1093-O-COM

File Number:
Date of Death:
Employee:

Dear :

We have been notified of the death of , who was receiving a schedule award of compensation from this office. If death was due to causes other than the injury for which the award was being paid, the remaining period of the award is computed at the rate of two-thirds of 's weekly pay rate when injured. Before we can determine the exact amount due, all uncashed compensation checks must be returned to us.

A widow or widower and eligible children have priority over other survivors. If there are no children eligible, the widow or widower is entitled to compensation for the remaining period of award. If children are eligible, one half is payable to the children shared equally, and one half to the widow or widower. If there is no widow or widower, the eligible children share the remaining compensation equally.

In the event neither widow, widower nor eligible children survive , the compensation can be paid to wholly or partially dependent parents, brothers, sisters, grandparents, and grandchildren at percentages specified by the Federal Employees' Compensation Act.

To be eligible for the compensation, children, brothers and sisters must be under 18 years of age, or if over 18, incapable of self-support because of physical or mental incapacity. If they are over 18 and are full-time students they continue to be eligible until they marry, complete four years of education beyond the high school level or reach age 23, whichever occurs first.

File Number:
Employee:

To claim benefits, complete either Part A or Part B of the attached application and return it to this office. Also, submit a copy of Claimant Name's death certificate which is certified by the public official having custody of the record. This information is necessary to obtain a benefit (5 U.S.C. 8101 et seq.).

Sincerely,

NAME OF SIGNER
TITLE

Enclosure(s): EN1093

CA1093-O-COM

File Number:
Employee:

APPLICATION FOR BALANCE OF SCHEDULE AWARD

Part A

SURVIVING HUSBAND, WIFE AND/OR CHILDREN

1. Name of deceased employee (last,first,mid)	2. Date of Death

SURVIVING HUSBAND OR WIFE (Items 3-9)

3. Name and address (include ZIP code)	4. Date of birth (Mo.,day,year)	5. Date of marriage to employee (Mo.,day,year)

6. Were you living with the employee at time of death? (_)Yes (_)No
7. Were you ever married to anyone other than employee? (_)Yes (_)No
8. Was employee ever married to anyone other than yourself? (_)Yes (_)No
9. How were the prior marriages terminated?

10. List all of the employee's children from this and prior marriages

Name	Date of Birth	Relationship To Employee	Address (include ZIP code)

I hereby claim compensation for the balance of the schedule award on behalf of myself and/or above listed children, who may be eligible for benefits.

11. Signature of person filing claim	12. Address (include ZIP code)	13. Date filed

File Number:
Employee:

PART B

DEPENDENT PARENT, BROTHERS, SISTERS, GRANDPARENTS, OR GRANDCHILDREN

1. Name of deceased employee (last,first,mid) | 2. Date of Death

3. Give the following information about all persons in above classes who are claiming benefits:

Name	Date of Birth	Relationship To Employee	Extent of Dependency	Address (include ZIP code)

ATTACH A SEPARATE SHEET GIVING FULL DETAILS OF EXTENT OF DEPENDENCY ON THE EMPLOYEE OF PERSON LISTED ABOVE. SHOW THE AMOUNT OF MONEY OR OTHER CONTRIBUTION WHICH WAS MADE DURING THE 12 MONTHS IMMEDIATELY PRIOR TO DEATH.

4. Signature of person filing claim	5. Address (include ZIP code)	6. Date filed

NOTICE TO RECIPIENT

Public reporting burden for this collection of information is estimated to vary from 15 to 45 minutes per response with an average of 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the US Department of Labor, OWCP, Room S3229, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS. Persons are not required to respond to this request unless it displays a currently valid OMB control number.